My Body DENTAL
www.mybodydental.com

162 Maroondah Highway
Croydon Vic 3136

# General Treatment Consent Form

**Please read and sign all items below:**

## 1. Treatment Required

I understand that I may have some of the following procedures at this appointment today: Local Anaesthesia, Radiographs (x-rays), Use of Diagnostic Aids, Preventive Hygiene Treatment (scale&clean and prophylaxis), Periodontal Treatment, Application of Topical Fluoride, Fissure Seals, Fillings, Desensitising Agent Application, Root Canal Treatment, Extractions (tooth removal), Whitening Treatments, Crowns, Bridges, Veneers and Dentures.

**Initial**_____

## 2. Changes to Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found whilst working on the teeth that were not discovered during initial examination, the most common being root canal treatment following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

**Initial**_____

## 3. Drugs And Medications

I understand that antibiotics and analgesics and other medications that may be prescribed for me by the Dentist can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction interfering with breathing). I also understand, for women, that antibiotics may alter the effectiveness of birth control pills. I understand there are possible risks and complications associated with the administration of Local Anaesthesia, sedation and drugs. The most common of these are: swelling, bleeding, pain, bruising, discolouration and injury to blood vessels and nerves, nausea, vomiting, pain/tingling/numbness of the gums/face/tongue/lips/chin (which may be permanent), allergic reactions, haematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I understand that occasionally needles break and may require retrieval by an oral surgeon. I also understand that there are rare potential risks such as: unfavourable reactions to medications resulting in respiratory and cardiovascular collapse/cardiac arrest (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death.

**Initial**_____

## 4. Payment

I understand that payment for treatment is required on the day. In the case of a third party being employed to recover any unpaid fees, the patient (or parent/guardian if under the age of 18) will be liable for any additional costs incurred.

**Initial**_____

I understand and have been informed of the above risks and complications, and consent to treatment.

**Name**_____ **Sign**_____ **Date**_____